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HB 2122 Testimony to
Senate Health & Human Services Committee

Chair Monnes Anderson,
Vice Chair Kruse, and
Members of the Committee:

Thank you for the opportunity to testify on HB 2122. For the record my name is Jo Bell, representing Capitol Dental Care. Capitol Dental Care (CDC) is a dental care organization (DCO) contracted with the state to deliver services under the Oregon Health Plan (OHP).

HB 2122 was introduced to correct an unintended consequence of SB 201 (2011 session) which allowed the Oregon Health Authority to approve the transfer of 500 or more enrollees from one managed care organization (MCO) or coordinated care organization (CCO) to another if the enrollee's provider no longer contracted with the transferring MCO/CCO but had a contract with a receiving MCO/CCO and the provider made a request to the agency to transfer enrollees. SB 201 is silent on the situation when an MCO/CCO terminates a provider for quality of care, competency, fraud or other similar reasons (for cause).

CDC has requested HB 2122 to clarify that, in the event of the termination of a provider for such reasons as stated above, the Agency may not approve the transfer of enrollees.

The intent of HB 2122 is to ensure that quality of care for members and related program requirements should be of the highest concern in a situation such as this and to clarify that SB 201 law and rules should not apply to a provider who has been terminated for "cause," as outlined in the bill and as defined in any current existing OHA statutes and rules. (See "Background Information," below on OHA contractual requirements.)

During the Committee work in the House Health Care Committee, there was only one issue brought forth to be addressed. The issue was the need to have a provider appeal process. Capitol Dental Care worked with Vice Chair Thompson and Advantage Dental to develop language for a provider appeal process. HB 2122-A Engrossed reflects the agreement that was

reached. I would note that, after many attempts to include language that prescribed the details of a process for provider appeal, it was agreed to allow the Oregon Health Authority to determine the details of the process, since OHA already has rule language about provider appeals and contested case hearings. Also, with the recent passage of SB 568, which requires OHA to develop mediation and arbitration processes for coordinated care organizations (CCO) and providers, OHA will be developing additional process language that may be used for this situation as well.

CDC requests your support of HB 2122-A. We believe that quality of care for members should be the foremost concern in such a transfer request situation. It is also the reason that we requested that the bill require an expedited process – which both protects the quality of care for the OHP members while recognizing the rights of the provider and the MCO/CCO to have a fair process to resolve any conflicts.

We will be happy to answer any questions.

Thank you!

Background Information:

CDC is required by the Agency to be compliant with our contract with OHA as well as to monitor and ensure the compliance of our participating providers with the requirements of the Oregon Health Plan. This responsibility includes ensuring participating providers provide Covered Services (as defined by DCO Contract) that are Dentally Appropriate care. Other responsibilities include adopting evidence based practice guidelines; requiring providers comply with member rights such as the right to receive information on available treatment options in a manner they understand; and the right to refuse treatment.

Should either we and/or our participating providers be non-compliant with OHP requirements, the Agency may impose sanctions on CDC and/or terminate our contract for Cause. In CDC's contract with our participating providers, we require they follow these same contract requirements as applicable to their services and so that we may remain compliant with OHA and our obligations.

In instances where an MCO/CCO determines a provider has substantially failed to meet quality of care standards or such contract requirements, the MCO/CCO is obligated to take action. There should not be a law where this action to protect members puts the MCO/CCO at risk of having the members removed from enrollment. An MCO/CCO decision to terminate a provider is not taken lightly; a decision to do so almost always follows attempts at corrective actions through other means that have failed.